

COBRA/CONTINUATION ELECTION/OPEN ENROLLMENT

UBEN 102 (R9/04W) University of California Human Resources and Benefits

COMPLETING THIS FORM

Section 1—Applicant Information The person applying for COBRA/continuation must be the **qualified beneficiary**—the employee, annuitant, or family member who is losing coverage. The applicant should complete the form and mail the appropriate copy(ies) directly to the health plan carrier(s).

The form must be mailed within 60 days from either the date on which you (the qualified beneficiary) would lose coverage under the plan by reason of a qualifying event, or the date you receive notice from UC about the right to elect COBRA/continuation coverage—whichever is later. If the form is not returned within this 60-day period, coverage cannot be continued under COBRA/continuation.

The employee's department or Benefits Office has information on plan premiums and mailing addresses. (Annuitants should call Customer Service at 1-800-888-8267.) This information is also available on the UC HR/Benefits website (<http://atyourservice.ucop.edu>). **The initial premium payment must accompany this election form.** After receiving your form, the health plan carrier(s) will explain the procedures for making continued payments.

Section 2—Type of Action Check the reason for completing the form and enter information as required.

Section 3—Election Complete this section fully. Be sure to give the date of the qualifying event. The plan(s) you elect to continue must be the one(s) you were enrolled in at the time of the qualifying event. Complete Section 5 if you want to continue coverage for eligible family members.

Section 4—Open Enrollment Changes To change plans during Open Enrollment, complete this section (and Section 5 if you want to add eligible family members). The new health plan carrier must receive this form and a check for the January premium by the Open Enrollment deadline. Note that your COBRA/continuation period starts on the date of the earliest qualifying event, not the date group coverage normally ends. Changes made during Open Enrollment do not alter the length of COBRA/continuation coverage. Open Enrollment changes will be effective on the announced date (usually the following January 1). For Open Enrollment information, please call Customer Service at 1-800-888-8267.

Section 5—Eligible Family Members List all eligible family members to be covered under the group plan(s) you select.

Section 6—Signatures The form must be signed and dated by the COBRA/continuation applicant and, in the case of an initial election, the Benefits Representative.

COBRA/continuation rights are subject to governing laws and regulations.

For complete information on COBRA/continuation coverage and other continuation options, please read the *Continuation of Group Insurance Coverage* notice, which includes eligibility requirements, definitions, and other details you should know. This publication is available on the UC HR/Benefits website (<http://atyourservice.ucop.edu>) under "Forms & Publications," from your Benefits Office, or from the person in your department who handles benefits.

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Shaded areas for Benefit Representative's use only.

1. APPLICANT INFORMATION

NAME OF COBRA/CONTINUATION APPLICANT (Last, First, Middle Initial)		DAYTIME PHONE	SEX <input type="checkbox"/> M <input type="checkbox"/> F
MAILING ADDRESS (Number, Street, City, State, ZIP)			
NAME OF EMPLOYEE/ANNUITANT		EMPLOYEE/ANNUITANT SOCIAL SECURITY NUMBER	CAMPUS/LAB

2. TYPE OF ACTION

<input type="checkbox"/> INITIAL COBRA/CONTINUATION ELECTION	<input type="checkbox"/> OPEN ENROLLMENT CHANGE	DATE OF ORIGINAL QUALIFYING EVENT:
<input type="checkbox"/> SECOND QUALIFYING EVENT		
<input type="checkbox"/> CALIFORNIA CONTINUATION COVERAGE		
<input type="checkbox"/> ADD NEWLY ACQUIRED DEPENDENT NAME:	DATE ACQUIRED:	<input type="checkbox"/> DELETE DEPENDENT NAME:
<input type="checkbox"/> MOVE OUTSIDE PLAN'S SERVICE AREA OLD PLAN:	NEW PLAN:	DATE OF MOVE:

3. ELECTION (ALSO COMPLETE SECTION 5)

Indicate the reason for COBRA/continuation by checking the event and providing the date of that event.

DATE OF QUALIFYING EVENT

- | | | |
|--|--|---|
| <input type="checkbox"/> Employment termination | <input type="checkbox"/> Layoff/approved leave without pay | <input type="checkbox"/> Death of employee/annuitant |
| <input type="checkbox"/> I am age 60 or older with 5 years of service immediately prior to termination (Please check "California Continuation Coverage" box in Section 2, above) | <input type="checkbox"/> Reduction of hours | <input type="checkbox"/> Child's or grandchild's loss of eligibility |
| | <input type="checkbox"/> Divorce/legal separation | <input type="checkbox"/> Adult dependent relative's loss of eligibility |
| | <input type="checkbox"/> Termination of same-sex domestic partner relationship | <input type="checkbox"/> Same-sex domestic partner's child's/grandchild's loss of eligibility |

Indicate the plan(s) you want to continue under COBRA/continuation.

MEDICAL <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT ELIGIBLE	NAME OF CURRENT PLAN	UC GROUP POLICY NO.	MEDICAL PLAN PROVIDER NAME OR #	DATE UC COVERAGE ENDS
DENTAL <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT ELIGIBLE	NAME OF CURRENT PLAN	UC GROUP POLICY NO.	DENTAL PLAN PROVIDER NAME OR #	DATE UC COVERAGE ENDS
VISION <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT ELIGIBLE	Vision Service Plan	0101923		DATE UC COVERAGE ENDS

4. OPEN ENROLLMENT CHANGES (ALSO COMPLETE SECTION 5)

TRANSFER INTO THIS PLAN	CANCEL THIS PLAN	UC GROUP POLICY NO. OF NEW PLAN	COVERAGE UNDER NEW PLAN			
MEDICAL PLAN NAME <input type="checkbox"/>	MEDICAL PLAN NAME <input type="checkbox"/>		SELF	SELF PLUS CHILD(REN)	SELF PLUS ADULT	SELF PLUS ADULT PLUS CHILD(REN)
DENTAL PLAN NAME <input type="checkbox"/>	DENTAL PLAN NAME <input type="checkbox"/>		SELF	SELF PLUS CHILD(REN)	SELF PLUS ADULT	SELF PLUS ADULT PLUS CHILD(REN)
VISION SERVICE PLAN <input type="checkbox"/>	VSP <input type="checkbox"/>					

5. ELIGIBLE FAMILY MEMBERS

List eligible family members (including yourself, if applicable) to be continued under, or added to, the group plan(s). Attach separate sheet if necessary.

LAST NAME	FIRST NAME	MIDDLE INITIAL	BIRTHDATE	RELATIONSHIP	SOCIAL SECURITY NO.
COBRA/CONTINUATION APPLICANT			MO DY YR	RELATIONSHIP TO EMPLOYEE/ANNUITANT	
ELIGIBLE FAMILY MEMBER			SEX <input type="checkbox"/> M <input type="checkbox"/> F	RELATIONSHIP TO COBRA APPLICANT	
ELIGIBLE FAMILY MEMBER			<input type="checkbox"/> M <input type="checkbox"/> F	RELATIONSHIP TO COBRA APPLICANT	
ELIGIBLE FAMILY MEMBER			<input type="checkbox"/> M <input type="checkbox"/> F	RELATIONSHIP TO COBRA APPLICANT	

*RELATIONSHIP: 1 = Self 2 = Spouse 3 = Former Spouse 4 = Natural/Adopted Child 5 = Stepchild 6 = Ward
 7 = Other Child 8 = Grandchild 9 = Same-sex Domestic Partner 10 = Same-sex Domestic Partner's Child/Grandchild 11 = Adult Dependent Relative (may not enroll after 12/31/03)

6. SIGNATURES

I agree to pay the total monthly premium directly to the plan carrier(s) listed above before the 10th of each month preceding the premium month. (For example, the June premium would be due by May 10.) I understand that failure to pay premiums will result in the termination of my group coverage. I also understand that UC will not pay for my coverage. I certify that I am not covered under Medicare. (NOTE: If this is an initial election or an Open Enrollment change, one month's premium payment must accompany this form.)

COBRA/CONTINUATION APPLICANT (Parent or legal guardian if dependents are minor children)			DATE
BENEFIT REPRESENTATIVE (Initial election only)	PHONE	CAMPUS/LAB	DATE

SEE REVERSE FOR PRIVACY NOTIFICATIONS

WHITE -MEDICAL CARRIER
 CANARY -DENTAL CARRIER
 PINK -VISION CARRIER
 GOLD -APPLICANT

TERMS AND CONDITIONS

By signing this form I agree to the following terms and conditions:

If I enroll family members, I certify that they are eligible for coverage based on the definitions and rules in the UC Group Insurance Regulations. I understand that UC and/or the various insurance carriers may periodically request proof of eligibility (marriage and/or birth certificates, adoption and/or tax records, documentation of same-sex domestic partnership or adult dependent relative relationship, etc.). I agree to provide such documentation upon request. I understand that if I do not, my family member(s) will be disenrolled retroactively and I will be liable for all costs incurred in connection with the invalid enrollment.

Most of the medical plans that UC offers (including the Blue Cross of California plans, Health Net, Kaiser Permanente, PacifiCare, Western Health Advantage, Definity Health, the UnitedHealthcare plans and PacifiCare Behavioral Health), as well as the PMI dental plan, require resolution of medical malpractice and other disputes through binding arbitration. When you enroll in these plans you agree that any dispute between you (and/or your enrolled family members) and the medical or dental plan must be submitted to binding arbitration. You agree to give up your right to a jury or court trial to resolve these disputes. For more information about each plan's arbitration provision, please see the appropriate plan booklet or call the plan.

PREMIUMS

If you elect COBRA/continuation or California continuation coverage, you will make the applicable monthly premium payments directly to the health plan carrier(s). Payments are due by the 10th of the month before the premium month—e.g., the June premium is due by May 10. The University will not contribute toward the cost of your group health coverage under COBRA/continuation or California continuation coverage. Premiums are subject to change at least once a year, usually January 1.

BENEFITS

Your coverage under COBRA/continuation or California continuation coverage will be the same as it is under your current UC-sponsored plan(s). If the group coverage changes, your coverage will change correspondingly. At the end of your COBRA/continuation or California continuation coverage continuation period, you may be able to convert your medical coverage to an individual, direct-pay policy. You may not convert your dental or vision plan.

PRIVACY NOTIFICATIONS

STATE

The State of California Information Practices Act of 1977 (effective July 1, 1978) requires the University to provide the following information to individuals who are asked to supply information about themselves.

The principal purpose for requesting the information on this form is for benefits administration.

Furnishing all information requested on this form is mandatory—failure to provide such information will delay or may even prevent completion of the action for which the form is being filled out.

The insurance carriers are responsible for maintaining the information contained on this form.

FEDERAL

Pursuant to the Federal Privacy Act of 1974, you are hereby notified that disclosure of your Social Security number is mandatory. Disclosure of the Social Security number is required pursuant to sections 6011 and 6051 of Subtitle F of the Internal Revenue Code and with Regulation 4, Section 404.1256, Code of Federal Regulations under Section 218, Title II of the Social Security Act, as amended. The Social Security number is used to verify your identity. The principal use of the number shall be as an identifier for your insurance carrier to verify your eligibility and to maintain claim records for you and your eligible family members.